Authorization for Emergency Medical Treatment

Name: _____
DOB: _____ Phone: _____
Address: _____
PCP Name: _____ Medical Facility: _____
Health Insurance Co: _____ Policy #: _____
Allergies to Meds: _____
Current Meds: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize **EquineWorks** to:

1. Secure and retain medical treatment and transportation if needed; and
2. Release client medical records (this document) upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the treating physician. This provision will only be invoked if the emergency contact (s) above is unable to be reached.

Date: _____ Signature: _____
Client, Parent or Legal Guardian
Signed in the presence of EquineWorks personnel

Non-Consent Plan

I do not give consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency medical aid/treatment is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Signature: _____I
Client, Parent or Legal Guardian

Signed in the presence of EquineWorks personnel